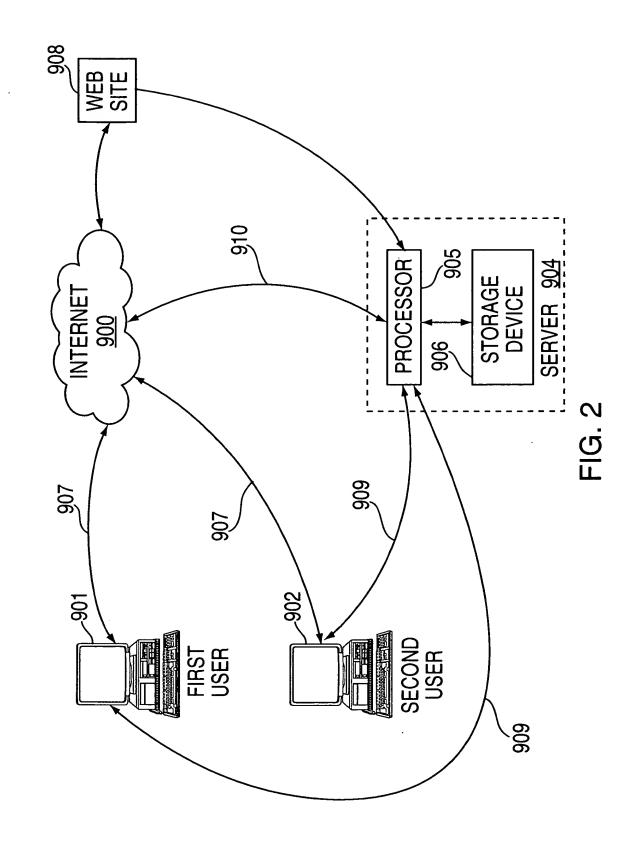
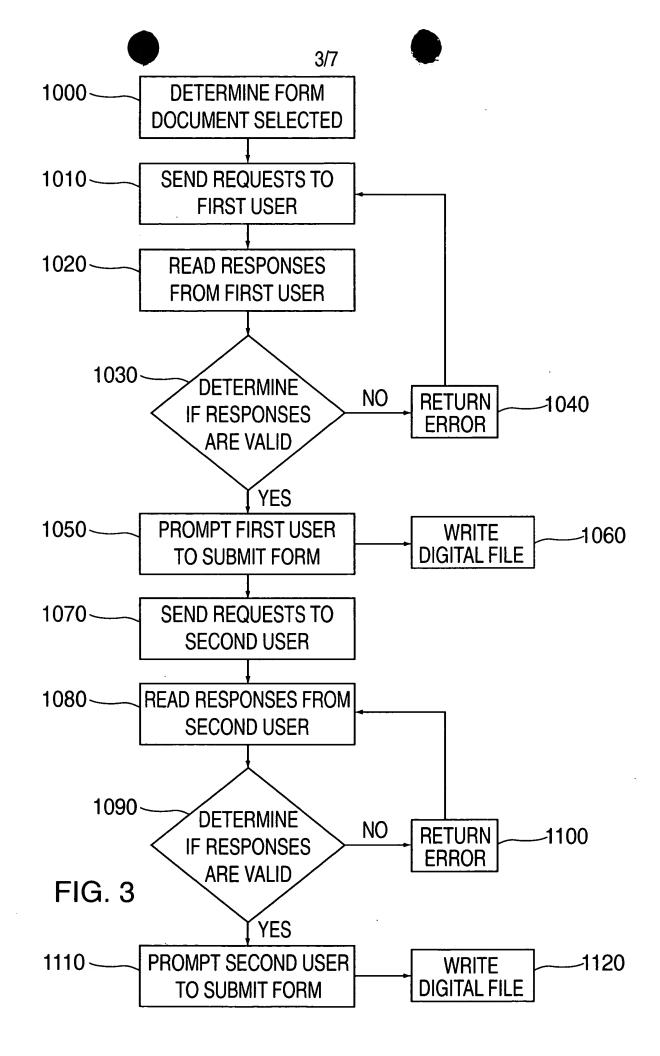
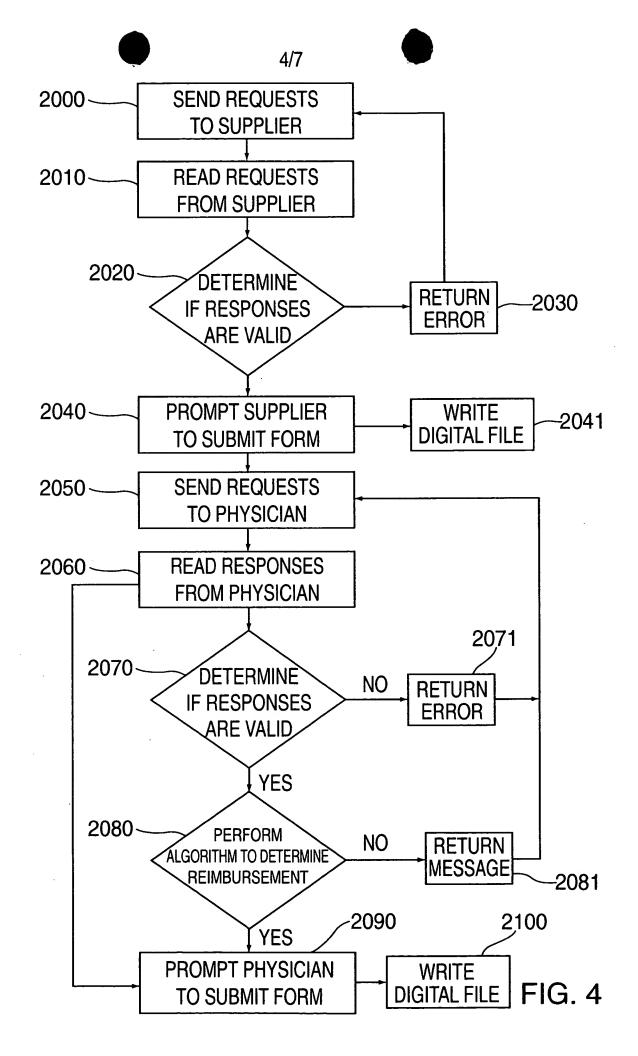
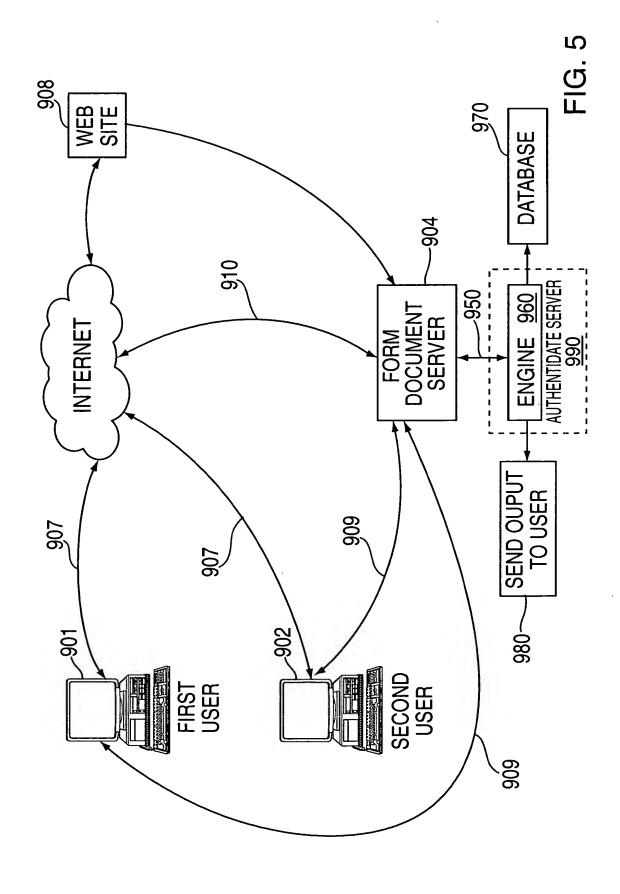
CERTIFICATE OF	MEDICAL NECESSITY DMERC 07.02A
SEAT LIFT MECHANISM	
SECTION A CERTIFICATION TYPE/DATE:	INTIAL/_/ REVISED/_/_
PATENT NAME, ADDRESS, TELEPHONE AND HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE AND NSC NUMBER
()HICN	(NSC#
PLACE OF SERVICE HCPCS CODE	PT DOB / / ; SEX(M/F); HT (IN.); WT (LBS.)
NAME AND ADDRESS OF FACULTY IF	PHYSICIAN NAME, ADDRESS (PRINTED OR TYPED)
APPLICABLE (SEE REVERSE)	PHYSICIAN'S UPIN:
	PHYSICIAN'S TELEPHONE #: ()
SECTION B INFORMATION IN THIS SECTION MAY N	OT BE COMPLETED BY THE SUPPLIER OF THE ITEMS/SUPPLIES.
EST. LENGTH OF NEED (# OF MONTHS): 1-99 (99=LIFETIM	E) DIAGNOSIS CODES (ICD-9):
ANSWERS ANSWER QUESTIONS 1-5 FOR SEAT LIFT MEC	
	FOR YES, N FOR NO, OR D FOR DOES NOT APPLY)
Y N D 11. DOES THE PATIENT HAVE SEVERE ARTHRIT Y N D 12. DOES THE PATIENT HAVE A SEVERE NEURO	
	NDING UP FROM A REGULAR ARMCHAIR OR <u>any</u> Chair in his/her home?
Y N D 4. ONCE STANDING, DOES THE PATIENT HAVE	THE ABILITY TO AMBULATE?
V N D 5. HAVE ALL APPROPRIATE THERAPEUTIC MODALITIES.	TO ENABLE THE PATIENT TO TRANSFER FROM A CHAIR TO A STANDING POSITION
NAME OF PERSON ANSWERING SECTION B QUESTIONS. IF OTHER T NAME:	ND FAILED? IF YES, THIS IS DOCUMENTED IN THE PATIENTS MEDICAL RECORDS. HAN PHYSICIAN (PLEASE PRINT):
	ESCRIPTION OF EQUIPMENT AND COST
(1) <u>NARRATIVE</u> DESCRIPTION OF ALL ITEMS, ACCESSORIES AND OPTIONS ORDERED; (2) SUPPLIER'S CHARGE; AND (3) MEDICARE FEE SCHEDULE ALLOWANCE FOR <u>EACH</u> ITEM, ACCESSORY, AND OPTION. (SEE INSTUCTIONS ON B ACK)	
ALLOWANCE FOR <u>EACH</u> ITEM, ACCESSONT, AND OF HON. (SEE INSTRUCTIONS ON BACK)	
•	
SECTION D PHYSICIAN ATTES	TATION AND SIGNATURE/DATE
I CERTIFY THAT I AM THE PHYSICIAN IDENTIFIED IN SECTION A OF THIS FORM, I	HAVE RECEIVED SECTIONS A, B AND C OF THE CERTIFICATE OF MEDICAL NECESSITY (INCLUDING
INFORMATION IN SECTION B IS TRUE, ACCURATE AND COMPLETE, TO THE BEST	ED HERETO, HAS BEEN REVIEWED AND SIGNED BY ME. I CERTIFY THAT THE MEDICAL NECESSITY OF MY KNOWLEDGE AND I UNDERSTAND THAT ANY FALSIFICATION, EMISSION, OR CONCEALMENT ABILITY.
OF MATERIAL FACT IN THAT SECTION MAY SUBJECT ME TO CIVIL OR CRIMINAL LI Physicians signature dat	ABILITY. E / / (signature and date stamps are not acceptable)









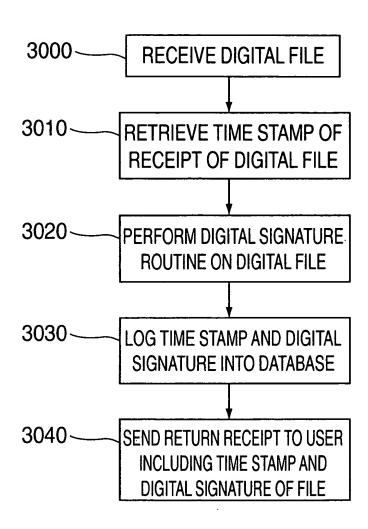


FIG. 6

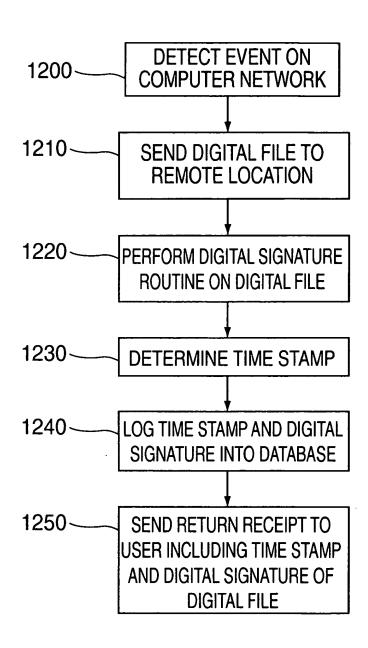


FIG. 7